

4

Conceptual and Definitional Issues in Complicated Grief

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Encounters with potentially traumatizing events are unfortunately common as evidenced by estimates that slightly over half of all U.S. citizens will experience such an event at some point during their life (Kessler, Sonnega, Bromet, & Nelson, 1995). Although life-threatening events are undeniably harrowing and elicit intense fear and acute psychological distress, the overwhelming majority of individuals exposed to such events do not develop chronic psychopathology (Breslau et al., 1998). Nevertheless, the ubiquity of traumatic exposure translates into a substantial number of individuals who will develop significant posttraumatic psychopathology, despite the relatively small percentage of trauma victims who develop chronic difficulties. For instance, even the most conservative estimates of the lifetime prevalence of posttraumatic stress disorder (PTSD) indicate that nearly 3 million U.S. citizens will develop the disorder at some point during their life (American Psychiatric Association, 1994). Because the majority of traumatic life events are life-threatening situations, mental health researchers and providers have understandably focused on disorders such as PTSD and acute stress disorder, which are primarily characterized by

pathological fear and anxiety. However, many severely distressing adverse life events involve the sudden, unexpected death of a close friend or relative instead of, or in addition to, personal life threat or endangerment. Notably, incidents of terrorism and mass violence typically yield a tremendous loss of life. For every survivor of such an atrocity, there is an untold number of suddenly bereaved individuals struggling with the death of a loved one who did not survive. Moreover, for every individual personally endangered by his or her proximity to such an event, there are countless individuals worldwide who are directly affected by the death of one of the victims. For example, the estimates for individuals bereaved as a result of the terrorist attacks on 9-11-01 in the United States alone is 6 million (Schlenger et al., 2002).

Although the mental health community has laudably stepped up its efforts to care for victims suffering from debilitating conditions that result from direct trauma, such as fear and anxiety, the emotional and psychological needs of the traumatically bereaved have been comparatively neglected. As of the writing of this chapter, a quick PsycINFO search revealed that articles addressing PTSD in the aftermath of incidents of mass violence or terrorism have outpaced articles addressing grief and bereavement issues following such events by a 3-to-1 ratio, despite the tremendous number of bereaved individuals who are left in the wake of such events. Although incidents of mass violence command a great deal of media attention, they account for a small portion of individuals experiencing complicated grief reactions. Much more prevalent but smaller-scale events such as motor vehicle accidents account for the great majority of traumas characterized by the death of a loved one. Further, despite this text's focus on early intervention following trauma and traumatic loss, it should be acknowledged that complicated grief reactions can ensue following deaths that are the result of natural causes as well. Complicated grief (CG), in its present conceptualization, does not disaggregate unique consequences which may be associated with deaths owing to frankly traumatic events such as homicide, natural disaster, or incidents of mass violence. It is abundantly clear at present that individuals experiencing the loss of a close friend or relative through any means—traumatic or nontraumatic—can develop chronic, unremitting, or otherwise severe grief reactions. What is unclear at present is whether the death of a loved one owing to particularly horrific causes (e.g., the World Trade Center attacks) is associated with unique complications in addition to or instead of PTSD or CG as it is presently conceptualized.

Limited knowledge exists on the differences between pathological grief reactions stemming from traumatic events relative to grief reactions stemming from deaths owing to natural causes. The few studies that have examined whether the traumatic nature of the death has an important influence on the

risk for CG and the severity of the CG response have actually yielded negative results (e.g., Prigerson et al., 2002). Although, more studies are needed before firm conclusions can be drawn about the role played by the nature of the death in vulnerability to CG, extant knowledge suggests that CG is equally likely to result from losses that are natural versus those that are unnatural. Consequently, findings pertaining to CG studied largely as the result of natural causes are expected to generalize to CG following from unnatural causes.

This chapter describes the constellation of symptoms that comprise the distinct clinical disorder of CG generally and distinguishes it from PTSD and major depressive disorder (MDD). As more empirical research bearing on the unique sequelae of loss by traumatic means accumulates (e.g., homicide), it is likely that different acute clinical management and treatment implications will emerge as well. At present, however, our observations are necessarily confined to complicated grief reactions generally as the CG literature is still in its infancy. We enumerate and describe etiological influences and risk factors for CG and also highlight adverse clinical outcomes associated with complicated grief reactions. Finally, we briefly describe treatment implications and review promising interventions for CG.

COMPLICATED GRIEF VERSUS UNCOMPLICATED GRIEF

Although researchers have long recognized that some individuals experience debilitating, unremitting distress following the death of a loved one, disagreement about defining features of a pathological grief reaction has prevented its establishment as a formal diagnostic entity in the nosology of mental disorders. Moreover, a historical focus on major depressive reactions following the death of a loved one has arguably resulted in an underestimate of individuals experiencing pathological grief reactions (Horowitz et al., 1997). As will be reviewed shortly, many bereaved individuals can experience chronic and debilitating grief-related distress without meeting diagnostic criteria for MDD. Recently, two separate groups of researchers have proposed diagnostic criteria for CG (Horowitz et al., 1997; Prigerson, Shear, et al., 1999). The relatively strong convergence in their independently proposed criteria is encouraging as it highlights the growing consensus in the field about the defining features of the disorder and, accordingly, increases the likelihood that unremitting psychological and emotional distress resulting from bereavement will be identified and treated.

As a result of a consensus conference convened to develop criteria for pathological grief reactions, Prigerson, Shear, et al. (1999) proposed that trau-

matic grief includes two core symptom categories. First, a person must be experiencing significant separation distress (Criterion A), as evidenced by at least three of the following four symptoms (experienced "often" or "always"): intrusive preoccupation or thoughts of the deceased, yearning for the deceased, searching for the deceased, or loneliness. Second, the person must be experiencing significant symptoms of traumatic distress in response to the death as evidenced by endorsement of at least 6 of the following 11 symptoms (occurring "often" or "always"): avoidance, futility about the future, numbness or detachment, feeling shocked or dazed, disbelief about the death, emptiness, feeling unfulfilled without the deceased, feeling that part of the self has died, shattered world view (e.g., lost sense of trust, security, or control), assuming symptoms or harmful behaviors of the deceased, or bitterness. At that time, the panel recommended that this constellation of symptoms needed to persist for at least 2 months after the death. This criterion has since been changed to a minimum duration of 6 months (Prigerson & Jacobs, 2001). Although it is recognized that this period may encroach on "normal" bereavement-related distress which may ultimately remit on its own, it provides an opportunity for identification and intervention for individuals experiencing pronounced difficulties a few months after the loss and who are at significantly heightened risk of physical and psychological morbidity in the coming years (Prigerson et al., 1997). Furthermore, recent longitudinal studies indicate that although there may be slight CG symptom remission beyond 6 months, symptoms have generally stabilized by this point (Prigerson et al., 1997). Finally, Criterion D requires that these disturbances cause significant impairment of social, occupational, or other important areas of functioning. It should be noted that the formal label of this proposed disorder has changed from traumatic grief to CG in recognition of the fact that sustained, pathological grief reactions can ensue following deaths resulting from natural causes (i.e., these clinical problems need not be triggered by a violent or accidental death).

Using common symptoms gleaned from interviews with bereaved individuals over the course of their adaptation to loss, Horowitz et al. (1997) also proposed criteria for a diagnosis of CG. As opposed to Prigerson et al.'s 6-month criterion, Horowitz et al. proposed that at least 14 months must elapse following the death of the loved one before a diagnosis of CG can be given. Although this time frame likely minimizes false positives, it may make it difficult to identify and treat severe grief reactions that might be effectively ameliorated earlier (Jacobs, Mazure, & Prigerson, 2000). With respect to the diagnostic criteria proposed by Horowitz and colleagues, any three of the following symptoms reported with sufficient intensity to interfere with daily functioning warrants a diagnosis of CG: intrusive memories or fantasies related to the lost

relationship, strong pangs of severe emotion related to the deceased, strong yearnings for the deceased, feelings of loneliness or emptiness, strong efforts to avoid people, activities or places that remind one of the deceased, disrupted sleep, or loss of interest in social, recreational, or occupational activities. Although further empirical research is needed to resolve the inconsistencies in the two sets of proposed diagnostic criteria (e.g., time elapsed following the death for the diagnosis to be given), the similarities provide evidence for the convergent validity of the CG construct.

Complicated grief is distinguished from "normal" or uncomplicated grief primarily by the presence of unremitting and incapacitating distress that interferes markedly with functioning. The loss of a significant other is inordinately distressing for virtually everyone. Most individuals experiencing such an event, however, experience an initial state of shock followed by acute emotional or somatic discomfort and social withdrawal but ultimately learn to accept the loss and resume prebereavement levels of functioning (Bowlby, 1963; Parkes & Brown, 1972). That is, they can eventually regain a sense of meaning and purpose, feel that the future holds potential for fulfillment, enjoy leisure and social activities, and generally function without significant impairment or acute distress. In contrast, those exhibiting complicated courses of bereavement do not exhibit a waning of symptoms over time but instead remain withdrawn, isolated, and severely emotionally distressed for several months or years following the loss. As will be reviewed shortly, this inordinate, sustained distress is associated with myriad adverse physical and psychological outcomes that do not typically ensue following normative bereavement processes. Moreover, as noted later, other diagnostic entities which have often been used to account for pathological grief responses often fail to adequately identify a substantial proportion of individuals experiencing significant grief-related psychopathology.

DISTINGUISHING COMPLICATED GRIEF FROM MAJOR DEPRESSIVE DISORDER

Although depressed affect is a universal response to the death of a loved one, and although CG and MDD are certainly not mutually exclusive possibilities, it would be a mistake to assume that severe grief reactions can be fully subsumed under the rubric of depression. First, in two separate studies of individuals who had recently suffered the death of a spouse, factor-analytic analyses revealed that symptoms of CG loaded highly on the first-order factor (i.e., the CG factor) but loaded quite poorly on anxiety and depression factors

(Prigerson et al., 1995; Prigerson et al., 1996). Accordingly, it is not simply the case that individuals experiencing pronounced symptoms of CG invariably experience concomitant severe depression. Moreover, in contrast to MDD, symptoms of CG have not been shown to respond to interpersonal psychotherapy alone or in combination with antidepressant medications (Pasternak et al., 1991; Reynolds et al., 1999). In addition, CG and MDD appear to entail distinct neuroendocrine responses (Jacobs, 1987) and sleep-state electroencephalography (McDermott, Prigerson, & Reynolds, 1997). Finally, and perhaps most important, in a sample of widowed individuals from the community, nearly half of the participants who endorsed clinically significant levels of CG did not meet diagnostic criteria for MDD (Prigerson et al., 1995; Prigerson, Bridge, et al., 1999; Silverman, Johnson, & Prigerson, 2001). Clearly, an exclusive focus on MDD criteria following bereavement experiences would result in a significant portion of severely distressed individuals going unidentified and untreated.

DISTINGUISHING COMPLICATED GRIEF FROM ADJUSTMENT DISORDER

As noted in DSM-IV (American Psychiatric Association, 1994), the hallmark feature of an adjustment disorder is significant emotional distress or behavioral symptoms in response to a readily identifiable psychosocial stressor. This would seem to be an appropriate depiction of complicated bereavement responses, but a diagnosis of adjustment disorder may not be given more than 6 months after the termination of the stressor. Both sets of independently proposed criteria for CG (Horowitz et al., 1997; Prigerson, Shear, et al., 1999) require that the symptoms persist for at least 6 months, thereby precluding a diagnosis of adjustment disorder. Within the first few months following the death of a loved one, the defining features of CG are not uncommon and are best conceptualized as normal responses to significant loss. It is only when the symptoms persist and contribute to sustained dysfunction that the course of bereavement can be considered complicated. Furthermore, the criteria for diagnosing adjustment disorder specifically prohibit this diagnosis in response to bereavement (American Psychiatric Association, 1994). Finally, criteria for adjustment disorder are notably imprecise and do not specifically reference the unique constellation of symptoms enumerated earlier (Prigerson, Shear, et al., 1999). Thus, although a diagnosis of adjustment disorder would connote that the bereaved individual was experiencing marked distress following the death of a loved one, the lack of specificity fails to provide direction for treatment planning.

DISTINGUISHING COMPLICATED GRIEF FROM POSTTRAUMATIC STRESS DISORDER

Although CG can ensue following loss from natural causes, it can also result from traumatic deaths, such as those resulting from motor vehicle accidents, homicides, suicides, and mass violence or terrorism (Prigerson et al., 2002). Although traumatic incidents that lead to loss of life routinely produce pronounced distress, and emotional and cognitive disorganization characteristic of acute stress disorder and loss by traumatic means is one of the most significant risk factors for chronic PTSD (Breslau et al., 1998), bereavement by traumatic means can lead to complicated bereavement as well. In theory, early intervention that neglects the unique psychosocial consequences of bereavement by focusing solely on acute stress disorder (ASD) can result in unaddressed, sustained, and unremitting grief-related distress. Because it is especially commonplace to diagnose survivors of such events with ASD/PTSD without necessarily considering unique features of the grief response, it is important to fully delineate the distinguishing features of the two disorders and their implications for early intervention and treatment.

Since the inclusion of PTSD in the psychiatric nosology (starting with DSM-III), loss by traumatic means (e.g., homicide) has been considered a traumatic stressor that could cause ASD/PTSD. However, PTSD fails to sufficiently capture the unique experiences of those who suffer from chronic grief as a result of violent loss of an important attachment figure. Nevertheless, Green (2000) and Green et al. (2001) argued cogently that loss by traumatic means should be treated as a traumatic stressor, and that the resulting chronic condition that arises in a small percentage of cases should be classified as PTSD. In this conceptualization, violent and unexpected loss results in severe feelings of personal vulnerability and forces the individual to confront the prospect of death, creating intense anxiety, which arguably is the psychological aftereffect common to all traumatic stressors.

In an attempt to study the effects of traumatic loss relative to non-loss-related trauma, Green et al. (2001) systematically studied the mental health outcomes in individuals with a single traumatic bereavement, those with a single non-loss-related trauma, and those with no traumatic experience. These researchers found that 16% of those who had experienced a loss by traumatic means met the criteria for PTSD and 22% met the lifetime criteria for a trauma-related disorder. The prevalence of major depression was no higher in the traumatic loss group, compared to the other two groups, which underscores the fact that the postloss syndrome is not simply depression or anhedonia. The most stigmatized deaths and those associated with malicious intent tended to produce higher rates of stress disorder. In fact, loss by traumatic

means led to more severe intrusive symptoms and greater functional impairment in comparison to a group of individuals who suffered physical assault, which suggests that loss by traumatic means may be more pernicious than direct trauma. Unfortunately, Green et al. (2001) failed to take into account the nature and extent of the attachment relationship in those who lost loved ones to violence. In addition, they failed to directly contrast PTSD as an outcome variable with symptoms of CG.

Although PTSD and CG can co-occur, CG is conceptually distinct from PTSD. Fundamental differences in defining features of the disorders have important treatment implications which may go unheeded if one hastily assigns a PTSD diagnosis without considering unique features of grief-related pathology.

With respect to the Criterion B (reexperiencing symptoms) of PTSD for instance, similarities between CG and PTSD are evident. Notably, both disorders may involve intrusive, distressing thoughts or memories related to the event in the case of PTSD or the deceased in the case of CG. However, reexperiencing symptoms of PTSD invariably results in heightened anxiety and distress. In contrast, "reexperiencing" types of symptoms of CG is not necessarily distressing or anxiety provoking. In fact, the bereaved individual actively yearns and searches for the deceased, and contact with reminders of the deceased is actually a source of comfort as opposed to a source of anxiety to be avoided (Rees, 1971). Although reminders of the deceased understandably trigger negative affective states because they are painful reminders of loss, they may also be a source of solace (Prigerson et al., 2000). Thus, in contrast to PTSD, "reexperiencing" symptoms can elicit ambivalent responses and reminders are sometimes actively sought instead of uniformly avoided. Despite the fact that reminders of the deceased can be comforting for those with CG reactions, excessive ruminations about the deceased may increase suicidal ideation as the bereaved may seek to be reunited with the deceased (Prigerson et al., 2000).

The avoidance and numbing symptom cluster of the PTSD construct (Criterion C) also overlaps with CG criteria, but yet again important differences are evident. In a recent empirical test of the performance of CG, item response theory (IRT) was used to evaluate the relationship of individual CG symptoms to a unidimensional construct of CG (Prigerson et al., 2000). Results indicated that "numbness" and "shattered world view" were most strongly related to the CG attribute. "Numbing" symptoms are a hallmark feature of PTSD, and fundamental alterations in one's belief system (i.e., a shattered world view) are common sequelae (McCann, Sakheim, & Abrahamson, 1988). However, numbness and detachment in instances of CG typically represent a

withdrawal from social activity and other interpersonal relationships as opposed to a volitional or unconscious attempt to dissociate from the event itself.

Perhaps, more central to distinguishing CG from PTSD is the symptom of avoidance. Although initially proposed consensus criteria for CG include avoidance, recent empirical evidence calls into question the importance of this symptom in identifying severe or protracted grief reactions. Specifically, the same IRT analysis described earlier revealed that avoidance demonstrated the poorest relationship to the CG construct and did not efficiently classify individuals with and without CG. Others have found that avoidance symptoms exhibit poor sensitivity in identifying CG (Horowitz et al., 1997) and may be infrequently endorsed among individuals experiencing sudden, unexpected deaths of loved ones (e.g., Spooen, Henderick, & Jannes, 2000). In contrast, avoidance is not only a defining feature of PTSD but is widely believed to be the most prominent factor in maintaining the disorder and, accordingly, most cognitive-behavioral interventions for PTSD explicitly target avoidance symptoms and behaviors (Resick & Calhoun, 2001). To the extent that avoidance is not central to CG, it would suggest that exposure-based treatments may be misguided in that they target fears that are not at the core of the disorder.

Criterion D for PTSD (hyperarousal) represents the greatest point of departure between PTSD and CG. Symptoms of increased arousal are seldom endorsed by those meeting criteria for CG. When "hypervigilance" does occur, it appears to be the result of the bereaved individual scanning the environment for reminders of the deceased and is therefore not akin to scanning the environment for danger or threat as is the case with PTSD (Raphael & Martinek, 1997). Unlike the case for PTSD, in which hypervigilance is a reaction to the fear that an horrific event will reoccur, in CG hypervigilance relates to a wish to be reunited and to regain contact with the missed person who had been lost.

Although there is no doubt that loss of an important attachment figure by violent means is potentially traumatizing and could result in symptoms of PTSD, there is also sufficient empirical evidence and compelling alternative conceptual frameworks to argue against a restrictive and narrow conceptualization of loss by traumatic means as psychological trauma. The "loss as trauma" framework proposed by Green (2000) fails to sufficiently acknowledge the unique biological, psychological, and social behavior implications of bereavement, which will color posttraumatic adaptation to loss by violence. In addition, within the field of traumatic stress, there is general consensus that certain types of traumatic events in certain contexts or developmental periods lead to unique posttraumatic outcomes. For example, although interpersonal trauma (incest, sexual assault, physical assault by caregivers and attachment figures, etc.) is defined in the same way as noninterpersonal trauma (e.g., motor vehi-

cle accident) in the diagnostic framework, interpersonal trauma leads to a dramatically different repertoire of posttraumatic deficits and liabilities, while sharing the same summary label of "PTSD" (e.g., Herman, 1992; Zlotnick, Zakriski, Shea, & Costello, 1996). In a similar vein, we argue that pathological grief responses can color the trauma of loss and develop in the absence of PTSD. There is certainly some degree of overlap between diagnostic criteria for CG and PTSD, but differences abound. This is most evident in studies that concurrently evaluate CG and PTSD in individuals experiencing recent deaths of loved ones.

In a study of friends of high school suicide victims assessed 6 years after the death, less than half of individuals exhibiting syndromal levels of CG also met diagnostic criteria for PTSD (Prigerson, Bridge, et al., 1999). Similarly, in a larger sample of recently widowed individuals, 66% of those meeting criteria for CG did not meet criteria for PTSD and over one-third of those individuals failed to meet diagnostic criteria for MDD or PTSD (Silverman et al., 2001). Thus, although there are some similarities among diagnostic criteria for these disorders, an exclusive focus on bereavement-related depression or PTSD would result in a significant proportion of individuals experiencing protracted, CG responses going undetected.

PSYCHOLOGICAL AND PHYSICAL MORBIDITY ASSOCIATED WITH COMPLICATED GRIEF

The distress associated with CG is certainly debilitating in its own right, but CG is also associated with substantive long-term psychological and physical impairments. Using follow-up data obtained from 76 young adults who had experienced the suicide of a close friend, Prigerson, Bridge, et al. (1999) found that participants who endorsed syndromal levels of CG were five times more likely to report suicidal ideation relative to individuals not experiencing elevated levels of complicated CG. CG was a significant predictor of suicidal ideation even after depressive symptoms were controlled in hierarchical regression analyses, indicating that CG is an independent risk factor for suicidal ideation.

CG has also been shown to be associated with an array of quality-of-life impairments. Silverman and colleagues (2000) evaluated a sample of 67 recently widowed individuals using a diagnostic interview for CG, structured interviews for PTSD and major depressive episodes, and a paper-and-pencil measure designed to evaluate functioning in eight domains: physical functioning, social functioning, limitations in activities of daily living, mental health, energy, pain, change in health within the past year, and general perceptions of current health. CG was a significant predictor of impairments in social func-

tioning, mental health, and energy level. These effects were significant after controlling for age, sex, time elapsed since the loss, and major depressive episode and PTSD diagnoses. The fact that these impairments are uniquely associated with CG above and beyond the effects of MDD and PTSD underscores the importance of considering symptoms and complications unique to the grief context.

In a longitudinal study of 150 widows and widowers, CG symptoms 6 months after the death of the spouse were significantly associated with adverse physical health (e.g., cancer, cardiac problems, and high blood pressure) and mental and behavioral health problems (e.g., suicidal ideation, changes in eating habits) at 13- and 25-month follow-up assessments (Prigerson et al., 1997). Once again, these associations remained significant after controlling for age, sex, and prior pathology. It may not be bereavement per se which places individuals at risk for adverse physical and emotional outcomes, but CG reactions may heighten one's risk for a number of subsequent physical and psychological outcomes.

Another recent study compared syndromal levels of CG, depression, and anxiety among widows and widowers in predicting mental and physical health outcomes (Chen et al., 1999). Syndromal levels of CG predicted adverse physical health events (e.g., myocardial infarctions and cancer) at 25 months for widows but not for widowers. High symptom levels of anxiety following the death of a spouse predicted suicidal ideation at 25 months among widowers. Whether the associations with deleterious mental and physical health outcomes are the result of a direct causal link or whether this relationship is mediated by poorer self-care, social withdrawal, or other maladaptive coping strategies remains to be explicated by future empirical studies.

ETIOLOGICAL INFLUENCES AND RISK FACTORS FOR COMPLICATED GRIEF

Given that CG can only be identified after many months have passed after loss, the crucial question that arises with respect to early intervention is: Who is most at risk for CG? In this context, a number of risk factors for the development of protracted grief reactions have been identified. Van Doorn, Kasl, Beery, Jacobs, and Prigerson (1998) investigated relationship characteristics which have been theorized to influence the course of bereavement. Specifically, they examined insecure attachment styles and relationships that may be characterized as very "security enhancing" (i.e., relationships typified by dependency on the partner, enhanced feelings of security, and active emotional support). These researchers found that security-enhancing marriages (evaluated

preloss) are significantly associated with CG and only modestly associated with depressive symptoms. CG was also significantly associated with a composite attachment style index (formed by aggregating excessive dependency, compulsive caregiving, and defensive separation attachment styles). In sum, a security-enhancing marital relationship and an insecure attachment style are independently predictive of CG symptoms. Not surprisingly, loss of close familial relationships (e.g., parent-child and spousal) is the best predictor of CG reactions (Cleiren, Diekstra, Kerkhof, and van der Wal, 1994; Prigerson et al., 2002).

There is accumulating evidence to suggest that adverse early life experiences such as parental loss and abuse in childhood may be associated with vulnerability to later-life bereavement difficulties (Prigerson et al., 1997; Silverman et al., 2001). Although speculative, such adversity may be operative by influencing the development of insecure attachment styles. Attachment disturbances may cause or exacerbate fears of abandonment, impulsivity, or difficulties with affect modulation which may become active when one is faced with the loss of a security-enhancing relationship (Prigerson et al., 1997). These reactions can ultimately result in a complicated, enduring pathological grief reaction.

Finally, there is some evidence to suggest that gender may be associated with differential susceptibility to CG following the death of a loved one. In a recent study of mental and physical health outcomes following the death of a spouse, widows had significantly higher symptoms of depression, anxiety, and CG relative to widowers (Chen et al., 1999).

TREATMENT FOR COMPLICATED GRIEF

Despite the fact that CG represents a relatively recent conceptualization of disordered functioning following bereavement, observations of severe or enduring pathological grief reactions have been noted in the clinical literature for decades (e.g., Freud, 1917/1953; Lindemann, 1944). Accordingly, there have been numerous therapeutic interventions spawned by clinicians from diverse theoretical perspectives to treat pathological grief reactions. As a general rule, the bulk of these interventions reported in the literature have not been evaluated in the context of controlled clinical trials; thus it is difficult to evaluate their efficacy. Nevertheless, some controlled trials of bereavement-specific interventions have been published, and a brief review of seemingly beneficial yet diverse interventions may be fruitful in identifying common "curative" elements.

Brief psychodynamic therapies have been used to treat recently bereaved individuals and have demonstrated significant symptom reductions over time (Horowitz, Marmar, Weiss, De Witt, & Rosenbaum, 1984; Marmar, Horowitz, Weiss, Wilner, & Kaltreider, 1988). However, active treatment conditions in these investigations did not exhibit symptom improvement that was appreciably greater than controls. Accordingly, it is not clear that treatment facilitated symptom improvement above and beyond that which may be expected as a function of the passage of time.

Behavior therapies for CG reactions have tended to focus on systematic exposure to avoided bereavement-related cues and reminders. These "guided mourning" interventions have generally been associated with significant reductions in "emotional distress" (not CG symptoms, *per se*) following bereavement. Once again, however, the data are somewhat mixed, with some investigations showing active treatment groups to improve significantly relative to controls (e.g., Mawson, Marks, Ramm, & Stern, 1981) and some showing comparable symptom reductions among treatment and control conditions (e.g., Sireling, Cohen, & Marks, 1988). In a study comparing an exposure-based behavioral intervention, hypnosis, and a brief psychodynamic therapy, all groups improved significantly relative to no-treatment controls (Kleber & Brom, 1987), suggesting that therapeutic contact for those experiencing psychological distress secondary to bereavement is superior to improvement that may be expected with the passage of time, though, again, these studies did not examine the effects of the treatments on the symptoms of CG explicitly. In contrast to many other investigations, a substantial proportion of participants in this study had experienced the loss of a loved one due to traumatic or otherwise unexpected causes, and all individuals were deemed to be experiencing "pathological grief." Accordingly, participants in this investigation were less likely to be experiencing uncomplicated courses of grief, and it may be that the majority of participants were experiencing psychological distress, including PTSD symptoms, that was unlikely to remit on its own over time.

Behavioral interventions' focus on exposure to avoided bereavement may not be fully instrumental in accounting for postbereavement improvement in light of recent research indicating that avoidance may not be especially common or influential in the development of CG (Horowitz et al., 1997; Spooen et al., 2000). Dismantling research would provide a test of the utility of this particular component relative to other components in behavioral treatment packages for bereavement. It may be that although CG is not generally characterized by marked avoidance, certain individuals (e.g., those who lost a loved one to an act of violence) experience greater levels of avoidance and that exposure-based interventions are more efficacious for this subset of individuals experi-

encing CG reactions by helping to reduce co-occurring PTSD symptomatology. Perhaps studies that have documented superior treatment gains using exposure-based methods have targeted samples endorsing higher levels of avoidance. This possibility remains to be empirically investigated.

Although therapy generally appears to be helpful in the amelioration of bereavement-related distress, no particular form of intervention has been shown to be superior. There are two (not necessarily mutually exclusive) implications that may be gleaned from this fact. First, it has been suggested that the nonspecific factors common to virtually all forms of psychotherapy are responsible for alleviating psychological distress stemming from bereavement (Raphael, Middleton, Martinek, & Misso, 1993), and that specific techniques may be less important. It may be that the compassionate, genuine, empathic relationship with the therapist is particularly important given that the source of the distress is the loss of a security-enhancing relationship. The therapist may help to fill this void to some small extent which may be partially responsible for treatment gains. Second, it seems quite reasonable to suppose that the optimal intervention for CG has yet to be developed. Because interventions to date have generally focused on symptoms of other disorders which may ensue following the death of a loved one as opposed to specifically targeting unique features of CG, it is possible that most trials of bereavement interventions have used less than optimal interventions and that future treatments tailored specifically to symptoms of CG will prove to be more efficacious (Jacobs & Prigerson, 2000).

What constitutes a CG-specific intervention? Recently, Shear et al. (2001) published pilot data for an intervention designed specifically to target symptoms of CG. The intervention was applied only to individuals experiencing significant symptoms of CG and consisted of 16 weekly sessions of individual therapy. The intervention included imaginal and *in vivo* exposure to cues and situations that the bereaved individual had been avoiding. Interpersonal therapy methods were also used to facilitate social reengagement and processing the meaning of the loss. In addition, patients provided a history of the relationship, provided an account of the circumstances surrounding the death, and described present relationships. A psychoeducational component was included to familiarize patients with symptoms of CG. Individually tailored hierarchies of avoided situations were obtained and imaginal and *in vivo* exposure exercises were conducted. The imaginal exercises were tape-recorded and patients were instructed to listen to these daily between sessions as homework assignments. Both the completer group (13 of 21 who began therapy) and the intent-to-treat participants exhibited significant reductions in symptoms of CG, depression, and anxiety. Although the sample was small, the methods were eclectic and in the process of development and standardization, and it was not

a controlled clinical trial, the authors noted that several patients demonstrated improvement when they had not benefited from the receipt of prior interventions.

Interventions should target those individuals who experience severe or protracted grief responses rather than bereavement generally. We wish to emphasize that we are not advocating interventions for all people surviving the death of a significant other because we recognize that the vast majority of bereavement individuals adapt effectively over time without the need for professional intervention. The majority of individuals experiencing the loss of a loved one will not experience CG, and severe acute distress that they may be experiencing following the death will typically abate over time without treatment. Previous studies that failed to document significant treatment gains in therapy conditions, relative to controls, may indeed have employed effective interventions, but if the control group exhibited significant spontaneous remission due to the normal course of bereavement (i.e., if the intervention was applied to any or all recently bereaved individuals instead of intervening only with those experiencing particularly severe or enduring grief reactions), it would be difficult to document a clinically significant treatment gain. Indeed, a recent meta-analysis of bereavement interventions (Neimeyer, 2000) revealed that bereavement interventions have been associated with very modest effects ($d = .13$). However, the average effect size of interventions which specifically targeted complicated bereavement reactions was three times as large ($d = .39$, which may be regarded as a medium effect size). Accordingly, it appears that treatment effects may be diluted if interventions are applied to any and all bereaved individuals, as most of these individuals would experience a significant remission of symptoms in the absence of treatment. Intervening only with individuals unlikely to exhibit such remission spontaneously would likely make it easier to document gains for truly effective treatments and would also be a more judicious use of limited clinical resources.

In terms of traumatic loss, the challenge for the future is to find ways of identifying individuals most at risk for CG and to provide a secondary prevention intervention specifically designed to reduce the risk for chronic CG. However, much more research is needed to identify individuals who will have the most difficulty adjusting to unpredictable and unexplainable loss on their own, over time. As is the case in the trauma field, in the absence of more conclusive risk factor research and randomized controlled trials of early interventions for CG in those most at risk, the most prudent and rational approach is to provide psychological first aid to anyone who suffers a tragic loss (especially a loss by means of malicious violence) and to provide information about the signs and symptoms of CG for victims and support persons to appeal to in the coming months, postloss. The recommendation would be that as soon as

symptoms of grief become unmanageable and as soon as there are significant problems reestablishing preloss levels of functioning, the person should be evaluated for treatment to prevent chronic CG. The intervention would be an amalgam of standard therapies, cognitive-behavioral approaches, and interpersonal treatment.

CONCLUSIONS

Although mental health professionals have long recognized that some bereaved individuals can have particularly severe or enduring complications following the death of a loved one, researchers and clinicians have tended to focus rather narrowly on grief reactions which mimic other disorders (i.e., MDD and PTSD) while failing to attend to unique bereavement-specific reactions. Although grieving individuals may endorse symptoms of MDD or PTSD, it has become apparent that CG is distinct from both disorders and that a substantial proportion of individuals experiencing complicated courses of bereavement fail to meet criteria for PTSD or MDD. Accordingly, an exclusive focus on these symptoms following a death may fail to identify numerous highly distressed individuals. Similarly, mental health professionals have become increasingly responsive to the psychological and emotional needs of victims of large-scale disasters and other traumatic events involving the loss of life. However, such attention has often focused exclusively on PTSD (as evidenced by outcomes measured in early intervention studies) and comparatively little attention has been paid to grief and bereavement issues that may result from such tremendous loss of life. Certainly, severe emotional distress following such events should not be pathologized. Profound grief following a trauma resulting in the death of a loved one is inevitable and is indisputably a normal human reaction to a horrific event. Most individuals will experience a gradual remission of symptoms and will be able to resume adaptive (if not prebereavement) functioning using their existing social supports and coping strategies. Many individuals, however, will experience unremitting symptoms of CG in the absence of formal intervention, and this is especially true for events involving tremendous loss of life such as incidents of mass violence, plane crashes, and so forth.

In the immediate aftermath of such an event, mental health professionals may promote adaptive recovery by educating victims about normal and CG reactions, providing information about common maladaptive coping strategies, encouraging utilization of existing social supports, and informing victims about mental health services that are available if victims feel that they need

more support. Moreover, although formal assessment in the immediate wake of such events is likely futile given that most survivors will be experiencing significant emotional distress as a normal human reaction to trauma, it may be possible in the future to screen for risk factors for CG in order to identify individuals who are likely to experience protracted grief reactions. At present, formal interventions for CG should include the treatment components reviewed previously, although the next decade will likely witness significant advances in the development of formalized treatment for CG. Additional complications in the course of bereavement or additional treatment implications as a function of the circumstances of death (e.g., traumatic vs. natural causes) may become apparent with additional empirical research. Regardless, traumatic events, which entail loss of life, should not narrow a clinician's focus exclusively to PTSD. If a traumatic event is compounded by the loss of life, it is imperative that mental health professionals attend to the unique needs of the bereaved and consider equally distressing but oft-neglected CG reactions.

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